

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington, *Petitioners*,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL
HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
and PETER SHALIT, M.D., Ph.D., *Respondents*.

*ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT*

JOINT APPENDIX

Christine O. Gregoire
Attorney General

*William L. Williams
Sr. Asst. Attorney General
P.O. Box 40113
Olympia, WA 98504-0113
(360) 753-4960

Counsel for Petitioner

*Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue 40th Fl.
Seattle, WA 98101-3099
(206) 583-8888

Counsel for Respondent

*Counsel of Record

PETITION FOR CERTIORARI FILED JULY 3, 1996
CERTIORARI GRANTED OCTOBER 1, 1996

INDEX

	Page
Documents Contained in Appendix to	
Petition for Writ of Certiorari.....	iii
Chronological List of Important Dates	v
Complaint for Declaratory Judgment	
and Injunctive Relief, filed Jan. 24, 1994	1
Declaration of Ralph Mero, M.Div., D.D.,	
dated Feb. 11, 1994	9
Declaration of Jane Roe,	
dated Feb. 1, 1994	22
Declaration of John Doe,	
dated Feb. 1, 1994	26
Declaration of James Poe,	
dated Feb. 1, 1994	29
Declaration of Harold Glucksberg, M.D.,	
dated Feb. 2, 1994	32
Declaration of Abigail Halperin, M.D.,	
dated Feb. 2, 1994	47
Declaration of Thomas A. Preston, M.D.,	
dated Feb. 1, 1994	53
Declaration of Peter Shalit, M.D., Ph.D.,	
dated Feb. 1, 1994	70
Declaration of Kathryn L. Tucker,	
dated Feb. 2, 1994	76
Attachments from Plaintiffs' Brief -	
Exhibit A - Excerpts from Amicus Brief	
of American Medical Assn et al. filed	
in <i>Webster v. Reproductive Health</i>	
<i>Services</i> [pages 26-38]	78

Exhibit B - Amicus Brief of Bioethicists for Privacy filed in <i>Webster v.</i> <i>Reproductive Health Services</i>	95
Plaintiffs' Motion for Summary Judgment, dated Feb. 3, 1994	128
Answer to Complaint for Declaratory Judgment and Injunctive Relief, dated Feb. 11, 1994	130
Attachments to Defendants' Brief - Appendix B - Report of the Counsel on Ethical and Judicial Affairs Regarding Physician Assisted Suicide	133
Appendix D - Model Penal Code and state statutes relating to assisted suicide	168
Declaration of John P. Geyman, M.D., dated March 10, 1994	187
Joint Motion for Entry of Final Judgment, dated May 19, 1994	229
Stipulation of the Parties Regarding Finality of Court's Order and Appeal, dated May 19, 1994	231
Order Entering Final Judgment, dated May 20, 1994	234
Notice of Appeal, dated May 24, 1994	237

DOCUMENTS CONTAINED IN THE APPENDIX TO THE PETITION FOR WRIT OF CERTIORARI

The following opinions, decisions, judgments and orders have been omitted in printing this Joint Appendix because they appear on the following pages in the appendix to the printed Petition for Certiorari.

Order of the United States District Court for the Western District of Washington Granting in Part and Denying in Part Plaintiffs' Motion for Summary Judgment and Denying Defendants' Cross Motion for Summary Judgment, dated May 3, 1993	E-1
Judgment of the United States District Court for the Western District of Washington, dated May 20, 1994	I-1
Opinion of the United States Court of Appeals for the Ninth Circuit, three-judge panel, entered March 9, 1995	D-1
Opinion of the United States Court of Appeals for the Ninth Circuit, limited en banc panel, filed March 6, 1996	A-1
Letter from Supreme Court Clerk notifying counsel that Justice O'Connor extended the time to file the Petition for Writ of Certiorari, dated May 14, 1996	F-1
Order of the United States Court of Appeals for the Ninth Circuit, limited en banc panel, amending majority opinion, filed May 28, 1996	B-1

Order issued by the Honorable Sandra Day O'Connor, Associate Justice, directing that the mandate of the United States Court of Appeals for the Ninth Circuit be recalled and stayed, dated May 29, 1996	J-1
Order in Pending Cases of the Supreme Court of the United States staying issuance of the mandate of the United States Court of Appeals for the Ninth Circuit pending disposition of the petition for writ of certiorari, dated June 10, 1996	K-1
Amended Order of the United States Court of Appeals for the Ninth Circuit denying request that full court rehear case en banc and dissenting opinions, filed June 12, 1996	C-1

CHRONOLOGICAL LIST OF IMPORTANT DATES

- | | |
|--------------------------|---|
| January 24, 1994 | Plaintiffs' Complaint for Declaratory Judgment and Injunctive Relief filed in U.S. District Court for the Western District of Washington at Seattle |
| February 3, 1994 | Plaintiffs' Motion for Summary Judgment filed |
| February 19, 1994 | Defendants' Answer to Complaint for Declaratory Judgment and Injunctive Relief filed |
| February 28, 1994 | Defendants' Memorandum in Opposition to Plaintiffs' Motion for Summary Judgment and in Support of Summary Judgment for Defendants filed |
| March 16, 1994 | Oral argument on cross motions for summary judgment |
| May 4, 1994 | Order Granting in Part and Denying in Part Plaintiffs' Motion for Summary Judgment and Denying Defendants' Cross Motion for Summary Judgment issued by District Court |
| May 19, 1994 | Stipulation of Parties Regarding Finality of Appeal and Joint Motion for Entry of Final Judgment entered |
| May 20, 1994 | Order Entering Final Judgment entered by District Court |

May 25, 1994	Defendants' Notice of Appeal to the United States District Court filed
December 7, 1994	Oral argument before a three-judge panel of the United States Court of Appeals for the Ninth Circuit
March 9, 1995	Opinion of the three-judge panel of the United States Court of Appeals for the Ninth Circuit filed
August 1, 1995	Plaintiffs' Petition for Rehearing and Suggestion for Rehearing En Banc to United States Court of Appeals for the Ninth Circuit granted
October 26, 1995	Oral argument before limited en banc panel of the United States Court of Appeals for the Ninth Circuit
March 6, 1996	Opinion of limited en banc panel of the United States Court of Appeals for the Ninth Circuit filed
March 25, 1996	Order directing parties to brief the issue of whether the case should be reheard before the entire United States Court of Appeals for the Ninth Circuit entered
March 26, 1996	Defendants/Appellants Motion to Stay Mandate filed with the United States Court of Appeals for the Ninth Circuit
May 6, 1996	Order denying stay of mandate unless reconsideration by the entire Court is granted entered by the United States Court of Appeals for the Ninth Circuit

May 14, 1996	Honorable Sandra Day O'Connor, Associate Justice, grants 30-day extension for filing Petition for Writ of Certiorari until July 4, 1996
May 29, 1996	Order entered denying rehearing before the entire Court entered by United States Court of Appeals for the Ninth Circuit Order entered by the Honorable Sandra Day O'Connor, Associate Justice, directing that the mandate of the United States Court of Appeals for the Ninth Circuit be recalled and stayed
June 10, 1996	Order entered by the Supreme Court of the United States staying the mandate of the United States Court of Appeals for the Ninth Circuit pending disposition of petition for writ of certiorari
June 12, 1996	Amended Order entered denying rehearing before the entire United States Court of Appeals for the Ninth Circuit, with three judges dissenting
July 3, 1996	Petition for Writ of Certiorari filed, docketed July 19, 1996 under cause No. 96-110
October 1, 1996	Order Granting Petition for Writ of Certiorari entered by the Supreme Court of the United States

JAN 24 1994

COPY RECEIVED ON
JAN 24 1994
CHRISTINE O. GREGOIRE
ATTORNEY GENERAL

BY _____
Assistant Attorney General

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING,)	
a Washington nonprofit	)	NO. C94-119
corporation, JANE ROE,)	
JOHN DOE, JAMES POE,)	
HAROLD GLUCKSBERG,	)	COMPLAINT FOR
M.D., ABIGAIL	)	DECLARATORY
HALPERIN, M.D.,	)	JUDGMENT AND
THOMAS A. PRESTON,	)	INJUNCTIVE RELIEF
M.D., and PETER SHALIT,)	
M.D., Ph.D.,)	
)	
Plaintiffs,)	
)	
vs.)	
)	
THE STATE OF)	
WASHINGTON and)	
CHRISTINE GREGOIRE,)	
Attorney General of)	
Washington,)	
)	
Defendants.)	
_____)	

INTRODUCTION

This action seeks a declaratory judgment of unconstitutionality and an injunction barring enforcement of the assisted suicide provision of RCW 9A.36.060. The relevant portion of the statute provides: “A person is guilty of promoting a suicide attempt when he knowingly . . . aids another person to attempt suicide.” The statute—by making assistance by physicians, family, or others a felony—prevents competent, terminally ill adults from exercising the right to choose to hasten inevitable death and thus avoid a lingering, painful death. The statute denies these individuals the liberty and privacy to decide what to do with their own bodies and lives and forces them to endure pain, anguish, and loss of dignity.

I. JURISDICTION AND VENUE

1.1 This action is brought under the United States Constitution and 42 U.S.C. § 1983 for violation of rights secured by the Fourteenth Amendment. The action seeks a declaratory judgment under 28 U.S.C. § 2201 and an order enjoining enforcement of the assisted suicide provision of the statute.

1.2 This Court has jurisdiction under 28 U.S.C. § 1331. Venue in this district is proper under 28 U.S.C. §§ 1391 and 2201.

II. PARTIES AND INTERESTS AFFECTED

2.1 Compassion in Dying (“Compassion”) is a Washington nonprofit corporation. Compassion assists competent, terminally ill adults who choose to hasten their deaths. Plaintiff Jane Roe has requested the assistance of Compassion. Compassion provides information, counseling, emotional support, and personal presence at the time of death. Compassion operates pursuant to a stringent protocol, one requirement being that the medications be self-administered by the individual seeking to hasten death.

Compassion fears that a criminal prosecution could be brought against it for its activities in assisting dying persons to exercise their choice to hasten inevitable death.

2.2 Jane Roe is a mentally competent, terminally ill adult. Jane Roe is a 69-year-old resident of King County, Washington, who is dying of cancer. Jane Roe is a physician and understands her condition and prognosis. Her cancer has metastasized into her bones and is growing rapidly throughout her entire skeleton. She has undergone surgery, chemotherapy, and radiation therapy, but the cancer is incurable. Jane Roe has been almost entirely confined to bed for the past seven months. Movement is intensely painful and her muscles have become so weak they cannot support her. To attempt to alleviate the extreme pain associated with bone cancer, Jane Roe relies on increasing doses of morphine. Even so, she is frequently in severe pain. Jane Roe has been advised and understands that her illness is a terminal one, that she is in the terminal phase of disease and that there is no chance of recovery. Jane Roe is fully aware of the ravages the disease wreaks and the prospect she faces of progressive loss of bodily function and integrity and increasing pain and suffering. Jane Roe seeks necessary medical assistance in the form of medications prescribed by her doctor to be self-administered for the purpose of hastening her death. Jane Roe desires the presence of members of plaintiff Compassion when she acts to hasten her death.

2.3 John Doe is a 44-year-old artist, living in King County, Washington suffering from AIDS. Mr. Doe has a T-cell count of four, leaving him vulnerable to all manner of infections with almost no natural ability to fight them. Mr. Doe has cytomegalovirus retinitis, which has caused him to lose approximately 70% of his vision to date and will result in blindness. Loss of vision is fatal to Mr. Doe's vocation and avocation, painting. Mr. Doe has

been hospitalized for AIDS-related pneumonia on several occasions. Mr. Doe suffers from chronic skin infections, sinusitis and grand mal seizures related to AIDS. Mr. Doe experiences extreme fatigue and his ability to care for himself is rapidly diminishing. Mr. Doe served as the primary caregiver for his long-term companion who recently died of AIDS at home in Mr. Doe's care. Mr. Doe witnessed firsthand the pain, suffering and loss of bodily function, integrity and personal dignity the disease causes. John Doe has been advised and understands that his illness is a terminal one, that he is in the terminal phase of the disease and that there is no chance of recovery. John Doe desires medical assistance in the form of medications prescribed by his doctor to be self-administered for the purpose of hastening his death.

2.4 James Poe is a mentally competent, terminally ill adult. James Poe is a 69-year-old resident of King County, Washington, who suffers from chronic obstructive pulmonary disease ("COPD") involving emphysema, bronchitis, and asthma. James Poe also suffers from heart failure caused in part by his COPD. The COPD makes it extremely difficult for James Poe to get enough air. He is connected to an oxygen tank at all times and is required to aspirate medications for hours each day to assist his breathing. He regularly experiences panic attacks associated with the sensation of suffocating and must take medication to calm this terror. James Poe's heart failure causes swelling of his lower extremities, resulting in lost mobility and pain. James Poe's only comfortable moments in life are when he is asleep; however, he can only sleep for two to three hours at a time. James Poe saw his mother die a slow, agonizing death and desires to avoid such a death himself. James Poe has been advised and understands that his illness is a terminal one, that his illness is incurable, and that he is, or soon will be, in the terminal

phase of the disease. When death is imminent and his suffering too great, James Poe wants the right to choose to hasten his inevitable death with medications prescribed by his doctor for that purpose.

2.5 Harold Glucksberg, M.D., is a physician licensed in the State of Washington who practices medicine in a major medical center in Seattle. Dr. Glucksberg specializes in the care of patients with cancer. Many of his patients are terminally ill and suffer severe and chronic pain. Approximately five to ten percent of his patients have cancer related to AIDS. In the regular course of his medical practice, Dr. Glucksberg encounters competent, terminally ill patients who express interest in the voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Glucksberg's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Glucksberg from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths. Dr. Glucksberg asserts his own constitutional rights and those of his patients.

2.6 Abigail Halperin, M.D., is a physician licensed in the State of Washington who practices family medicine in Seattle. Some of Dr. Halperin's patients are terminally ill. On occasion she encounters competent, terminally ill patients who express interest in the voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Halperin's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Halperin from exercising her best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own

deaths. Dr. Halperin asserts her own constitutional rights and those of her patients.

2.7 Thomas A. Preston, M.D., is a physician licensed in the State of Washington who practices medicine in Seattle. Dr. Preston is a cardiologist and is Chief of the Cardiology Division at a major medical center. Dr. Preston treats patients who are terminally ill and, on occasion, encounters competent, terminally ill patients who express interest in the voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Preston's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Preston from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths. Dr. Preston asserts his own constitutional rights and those of his patients.

2.8 Peter Shalit, M.D., Ph.D., is a physician licensed in the State of Washington who practices internal medicine in Seattle. Approximately thirty percent of his patients suffer from AIDS, an incurable disease. AIDS patients typically suffer from recurrent infections that wear the body down. Many AIDS patients develop cancer. Cancer of the lungs is common among AIDS patients, causing extreme shortness of breath and the terrifying sensation of suffocating. AIDS patients have typically witnessed the deaths of other persons from AIDS and are aware of the course the disease takes. Many of Dr. Shalit's competent, terminally ill patients express interest in voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Shalit's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Shalit from exercising his best professional judgment to prescribe medications to these patients in dosages that

would enable them to act to hasten their own deaths. Dr. Shalit asserts his own constitutional rights and those of his patients.

2.9 The State of Washington is a governmental entity.

2.10 The Attorney General of the State of Washington, Christine Gregoire, is the chief law enforcement officer of the State of Washington and acts under color of the law in enforcing RCW 9A.36.060. She is sued in her official capacity and as representative of all law enforcement officers in the State.

2.11 There exists an actual, justiciable controversy among these parties as to the validity of the statute.

III. CAUSES OF ACTION

3.1 The Fourteenth Amendment protects the right of competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering. The right to make this choice is a fundamental right and is entitled to the strongest degree of constitutional protection.

3.2 The Fourteenth Amendment protects the right of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

3.3 RCW 9A.36.060 denies plaintiffs the equal protection of the laws by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise

this choice, with necessary medical assistance, by directing termination of such treatment.

3.4 Plaintiffs have no adequate remedy at law and face imminent and irreparable loss of their rights. Plaintiffs continue to undergo unnecessary pain and anguish. Absent expedited consideration and prompt injunction against enforcement of RCW 9A.36.060, plaintiffs will continue to suffer substantial and irreparable harm and their rights will be finally and fully denied before this Court can rule.

IV. PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that this Court grant the following relief:

4.1 A declaration that the assisted suicide provision of RCW 9A.36.060 is invalid under the United States Constitution.

4.2 A declaration that the assisted suicide provision of RCW 9A.36.060 violates 42 U.S.C. § 1983.

4.3 An order permanently enjoining defendants, and all who act in concert with them, from enforcing the assisted suicide provision of RCW 9A.36.060.

4.4 An award of plaintiffs' costs, expenses, and reasonable attorneys' fees pursuant to 42 U.S.C. § 1988.

4.5 Such other and further relief as this Court deems just.

DATED: January 24, 1994.

PERKINS COIE

David J. Burman

Thomas L. Boeder

By ____/s/

Kathryn L. Tucker

Attorneys for Plaintiffs

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING,)	
a Washington nonprofit	)	NO. C94-119
corporation, JANE ROE,)	
JOHN DOE, JAMES POE,)	
HAROLD GLUCKSBERG,	)	DECLARATION OF
M.D., ABIGAIL	)	RALPH MERO,
HALPERIN, M.D.,	)	M.DIV., D.D.
THOMAS A. PRESTON,)	
M.D., and PETER SHALIT,)	
M.D., Ph.D.,)	
)	
Plaintiffs,)	
)	
vs.)	
)	
THE STATE OF)	
WASHINGTON and)	
CHRISTINE GREGOIRE,)	
Attorney General of)	
Washington,)	
)	
Defendants.)	
_____)	

RALPH MERO declares:

1. I am the Executive Director of Compassion in Dying, a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am an ordained Unitarian Universalist minister with graduate degrees from Meadville Lombard Theological School at the University of Chicago. I have been employed in parish ministry with a local congregation and also in community miniseries in health care administration. I am an experienced counselor and trainer of counselors, and have extensive experience in dealing with the personal, familial, and societal aspects of death and dying.

3. Compassion in Dying is a nonprofit charitable organization incorporated in Washington State in April 1993 for the purpose of providing information and counseling to mentally competent, terminally ill adult patients—and their families—in situations where the patients are considering the option of hastening inevitable death. These services are provided at no charge.

4. Terminally ill patients contact Compassion in Dying seeking assistance in shortening the period of suffering before death, and all end-of-life decisions are made by the patient. The family must concur with the patient's decision to hasten death in order for Compassion to be involved. These hastened deaths are facilitated by drugs obtained by, and self-administered by, the patient.

5. Compassion in Dying has stringent eligibility requirements and provides its services only to individuals who are determined by independent medical judgment to be mentally competent and in the end stage of their disease. The eligibility criteria of Compassion are contained in our Guidelines and Safeguards and are set forth as Exhibit 1.

6. Compassion in Dying has stringent Protocol describing the process for assisting with the hastened

deaths of eligible individuals. That Protocol is set forth as Exhibit 2.

7. With members of our Board of Directors, I have been present at several hastened deaths when requested by terminally ill patients and their families. Our presence is provided so that these patients do not have to die alone or to provide emotional support for any family members who are also present.

8. Plaintiff Jane Roe has requested my presence and that of one of our Board members at the time she acts to hasten her death. She is eligible under our criteria. An interview I conducted with Jane Roe on January 20, 1994, about her medical condition and her desires regarding her dying process was video recorded. Plaintiff Jane Roe is very desirous that her true identity not be divulged to the press and public. A complete and unedited copy of that recording will be submitted as soon as a protective order is entered prohibiting disclosure of Jane Roe's true identity.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 1st day of February, 1994.

/s/
RALPH MERO, M.Div., D.D.

COMPASSION IN DYING

PO Box 16483 - Seattle, WA 98116 - 202/624-2775

**GUIDELINES AND SAFEGUARDS
FOR ASSISTED SUICIDE**

A. GUIDELINES

1. Who is eligible?
 - a. The patient's condition must be considered terminal in the judgment of the patient's primary-care physician; i.e., the patient suffers from an incurable condition which, according to reasonable medical judgment, will result in death within a reasonable period of time, regardless of continued treatment.
 - b. The patient's condition must cause severe, unrelenting suffering which the patient finds unacceptable and intolerable.
 - c. The patient must understand the condition, prognosis, and types of comfort care which are available as alternatives to suicide.
 - d. The patient's condition and prognosis must be confirmed by one or more physicians who review the records and examine the patient, to the extent that these are possible without compromising the dignity of the patient.
2. Quality of care being received.
 - a. It must be clear that the patient's suffering and request for assisted suicide are not the result of inadequate hospice or comfort care.

EXHIBIT 1

- b. It must also be clear that the patient's request for assisted suicide is not motivated by lack of adequate health insurance or other economic concerns.
- 3. The process of requesting assistance.
 - a. The request for assistance with suicide must originate with the patient. The request must be made in writing or on videotape on three (3) occasions, with an interval of at least 48 hours between the second and third requests.
 - b. All requests and records will be kept confidential.
 - c. Any indication of uncertainty or ambivalence on the part of the patient will cancel the process leading toward assisted suicide.
 - d. Requests may not be made through advance directives or by a health-care surrogate, attorney-in-fact, or any other person.
- 4. Mental health considerations.
 - a. Evaluation by a mental-health professional may be obtained to ensure that the patient's request is not motivated by depression, emotional distress, or mental illness.
 - b. The patient must be capable of understanding the decision and its implications and must take responsibility for the decision.
- 5. Family and religious considerations.
 - a. If the patient has family members or others with whom he or she is in close personal relationship, their approval must be obtained. Assistance with suicide will not be

provided if there is expressed disapproval by members of the immediate family.

- b. Spiritual and emotional counseling may be offered or arranged, depending on the patient's background and beliefs.
6. Who can assist?

The patient may ask for and receive assistance from the individuals in whom he or she has the most confidence and with whom he or she is the most comfortable. Volunteer health-care personnel and others will develop a relationship with the patient in order to become assured that a hastened death is the most appropriate outcome, given the condition and suffering of this particular patient.

B. SAFEGUARDS

1. Terminally ill persons who meet the medical, emotional, and situational criteria for assisted suicide, as outlined in the Guidelines for Assisted Suicide, must make a documented request for assistance with their own suicide, stating in detail the nature of the assistance they need.
2. Three requests must be made. The patient's initial request for assistance must be made in writing or on videotape. This must be followed by two additional requests in writing or on videotape, with at least 48 hours between the second and third requests. Such requests cannot be made through advance directives or by health-care surrogates, family members, or persons other than the patient.

3. COMPASSION representatives trained in working with the terminally ill will meet with the patient making the application—and his or her immediate family, if possible. Copies of the patient's medical records and other pertinent information will be requested.
4. The consulting physician will, through examination of the patient and review of the medical records, verify both the terminal prognosis and the patient's decision-making capacity. This may include consultation with the patient's primary-care physician. The consulting physician will be Board certified or will have equivalent professional experience.
5. If the physician reviewing the case determines a need to rule out depression or any other emotional factors which may indicate confused judgment, the physician shall request an evaluation by a qualified mental-health professional. In such an instance, no effort to assist with suicide will proceed until the assessment has been made and has confirmed the patient's capacity to understand the situation, and until the physician is convinced that the decision is both voluntary and rational. During the course of this process, the patient may receive in-depth counseling and emotional support, but there shall be no effort to assist with suicide during this review.
6. The reviewing physician will ascertain that the request for assistance with suicide does not result from inadequate hospice, palliative, or comfort care, or from inadequate efforts to control pain. If unmanaged pain is an issue, alternative or more intensive palliative care will be recommended.

7. Any sign of indecision or uncertainty on the part of the patient, or opposition on the part of the immediate family, will cancel the process leading toward assisted suicide.
8. The physician and others who have reviewed the records and interviewed the patient will meet in case conference to consider if assistance is needed and warranted. The decision of this group to proceed with assistance must be unanimous.
9. The patient may request that representatives of COMPASSION be present during his or her suicide to provide emotional support and assist with the patient's predetermined plan for ending life. If this is requested, two representatives of COMPASSION will be present. One will keep a written record of the times and events leading up to the moment of death.
10. The actual means of suicide will vary according to the underlying condition of the terminally ill patient and the types of medication available. Assistance with suicide under these safeguards will not involve any means of hastening death which rely on violence.
11. Following an assisted suicide, ongoing emotional and/or spiritual support will be offered to surviving family members or others who so request. Information may also be provided about grief and bereavement resources available in the community.
12. To assure that the process of dying is humane and respectful of the patient's innate sense of human dignity, there shall be no breach of confidentiality disclosing the identity of a patient who has

received assistance with suicide or the identity of persons who provided assistance.

COMPASSION IN DYING

PO Box 16483 - Seattle, WA 98116 - 202/624-2775

PROTOCOL FOR ASSISTED DYING

1. Receipt of initial request for information from patient or family, usually by phone.
2. Personal interview with patient, and family if possible, by Executive Director or Board member to explore alternatives and make preliminary determination that patient meets the requirements for assistance from COMPASSION. During this interview, the patient may complete the **FIRST FORMAL REQUEST FOR ASSISTANCE**, in writing or videorecorded.
3. Assignment of Case Review Team (CRT) consisting of:
 1. Executive Director or substitute from Board of Directors
 2. Nurse, mental health professional, or other person experienced in working with the terminally ill.
 3. Trained volunteer, selected to serve as primary liaison with patient, plus physician from Advisory Committee to serve as consultant to CRT.
4. Provision of counseling and emotional support, with second exploration of alternatives.

Patient must continue determination to commit suicide as only appropriate course of action.
5. **MEDICAL REVIEW.** Examination of patient and medical records by an independent physician to confirm that patient meets medical requirements for assistance from COMPASSION. Consultation with primary care physician, if at all possible.

6. First review by CRT and report to Executive Director or a Board Review Committee appointed for this purpose.

7. **SECOND FORMAL REQUEST FOR ASSISTANCE** from patient, followed by further counseling and emotional support. Third exploration of alternatives. Discussion of specific plan for suicide by prescription medications.

8. Second review by CRT and report to Board Review Committee, if patient plans to continue with suicide.

9. **THIRD FORMAL REQUEST FOR ASSISTANCE** from patient. *At least 48 hours must transpire between 2nd and 3rd requests.*

10. Third review by CRT and report to Board Review Committee.

Development of plan for assistance, with clear understanding of COMPASSION'S limits and agreement of family members.

11. Further counseling to be sure that patient wishes to proceed with suicide.

Fourth review of alternatives.

12. Presence at the time of death if patient is determined to commit suicide and so requests.

COMPASSION IN DYING PROTOCOL FOR ASSISTED SUICIDE

1. Receipt of initial request for information from patient or family, probably by phone.
2. Personal interview with patient, and family if possible, by Executive Director or Board member to explore alternatives and make preliminary determination that patient meets the requirements for assistance from COMPASSION. During this interview, the patient may complete the FIRST FORMAL REQUEST FOR ASSISTANCE, in writing or videorecorded.
3. Assignment of three person Case Review Team (CRT) consisting of:
 1. Executive Director or substitute from Board of Directors
 2. Nurse, mental health professional, or other person experienced in working with the terminally ill.
 3. Trained volunteer, selected to serve as primary liaison with patient, plus physician from Advisory Committee to serve as consultant to CRT.
4. Provision of counseling and emotional support, with second exploration of alternatives.

Patient must continue determination to commit suicide as only appropriate course of action.

5. **MEDICAL REVIEW.** Examination of patient and medical records by an independent physician to confirm that patient meets medical requirements for assistance from COMPASSION. Consultation with primary care physician, if at all possible.

6. First review by CRT and report to Executive Director or a Board Review Committee appointed for this purpose.
7. **SECOND FORMAL REQUEST FOR ASSISTANCE** from patient, followed by further counseling and emotional support. Third exploration of alternatives. Discussion of specific plan for suicide by prescription medications.
8. Second review by CRT and report to Board Review Committee, if patient plans to continue with suicide.
9. **THIRD FORMAL REQUEST FOR ASSISTANCE** from patient. *At least 48 hours must transpire between 2nd and 3rd requests.*
10. Third review by CRT and report to Board Review Committee. Development of plan for assistance, with clear understanding of COMPASSION'S limits and agreement of family members.
11. Further counseling to be sure that patient wishes to proceed with suicide.
Fourth review of alternatives.
12. Presence at the time of death if patient is determined to commit suicide and so requests.
13. On-going emotional support for the family, if requested.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING,)	
a Washington nonprofit	)	NO. C94-119
corporation, JANE ROE,)	
JOHN DOE, JAMES POE,)	
HAROLD GLUCKSBERG,	)	DECLARATION OF
M.D., ABIGAIL	)	JANE ROE
HALPERIN, M.D.,)	
THOMAS A. PRESTON,)	
M.D., and PETER SHALIT,)	
M.D., Ph.D.,)	
)	
Plaintiffs,)	
)	
vs.)	
)	
THE STATE OF)	
WASHINGTON and)	
CHRISTINE GREGOIRE,)	
Attorney General of)	
Washington,)	
)	
Defendants.)	
_____)	

JANE ROE declares:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. Jane Roe is not my real name; I use this fictitious name in this lawsuit to protect my privacy.

3. I am 69 years old and am a pediatrician. I received my medical degree from Vanderbilt Medical School in 1953. I have been married for 38 years to my husband who is also a physician. We have 2 grown children.

4. In 1973 a lump in my right breast was determined to be malignant. I underwent surgery to remove my right breast. I then underwent chemotherapy to further treat the breast cancer.

5. To my knowledge, I was free of cancer until the fall of 1988. Efforts to stop the cancer since then have not succeeded. At this time, the cancer has metastasized into my bones and is now found throughout my skeleton, including my skull, spine, rib cage and pelvis.

6. I underwent radiation therapy with fairly good results until early 1993, at which point the cancer became much more painful. Surgery is not an option and chemo-therapy cannot be repeated due to bone marrow depression.

7. Beginning in June 1993 and continuing to the present, I have been almost entirely bedridden due to a combination of pain associated with the cancer in my bones and the diminishing strength in my muscles as I use them less and less. I am now unable to walk or use the commode or a bed pan without assistance. My legs are swollen with severe edema and I can scarcely use them. I have developed bed sores as a result of being bed bound. My appetite is poor and I take medications to prevent nausea and vomiting. My vision is often impaired. My left hand is weak. Drowsiness is a frequent problem. I

have an indwelling urinary catheter and am sometimes incontinent of bowel.

8. The pain associated with this cancer is unrelenting. It is a constant, dull pain, interspersed with sharp, severe pain provoked by movement. The site of pain moves as the disease advances.

9. I take a variety of medications to manage pain. There is a tension between taking enough medication to alleviate the pain and retaining an alert mental state. It is not possible to eliminate my pain and for me to retain an alert state.

10. I have experienced a variety of adverse side effects with each treatment regimen. Chemotherapy caused bone marrow depression, fatigue, severe bladder irritation, diarrhea and nausea. Radiation caused further bone marrow depression, requiring repeated blood transfusions; severe bleeding; diarrhea; fatigue; severe sore throat; and first degree skin burns. My medications cause severe constipation, drowsiness, difficulty concentrating, and dry mouth.

11. Since the cancer was diagnosed to the present I have pursued medical treatment. The fact that both I and my spouse are doctors has enhanced my understanding of my condition and options. I believe that I have received good treatment and have benefited from it. At this point, it is clear to me, and based on the advice of my doctors, that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures. The sole medical treatment available is pain relief, which is not able to eliminate my frequent and severe pain.

12. In November 1993 my doctor referred me for hospice care, and I am receiving home hospice care. To be eligible to receive hospice care I must have no more than six months life expectancy.

13. At the point at which I can no longer endure the pain and suffering associated with my cancer I want to have drugs available for the purpose of hastening my death. I no longer am licensed to prescribe drugs myself, and do not know the best combination of substance and dosage.

14. At the time I act to hasten my death I would like members of Compassion in Dying to be with me and members of my family to provide counseling, emotional support, and any necessary ancillary assistance, such as mixing the drugs to be consumed. I do not want to have to die alone and unsupported. I have made three formal written requests to Compassion in Dying for their assistance as is required by that organization. I participated in a video-taped interview conducted by Ralph Mero of Compassion in Dying on January 20, 1994, which I understand will be submitted in this proceeding. That interview also accurately describes my medical condition and my desires with regard to my dying process.

15. I am mentally competent. I have no current or historical mental health problems that would impair my decision-making powers regarding end-of-life decisions.

**I declare under penalty of perjury under
the laws of the United States of America
that the foregoing is true and correct to
the best of my knowledge.**

Executed at Mercer Island, this 1st day of February,
1994.

A/K/A JANE ROE

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING,)	
a Washington nonprofit	)	NO. C94-119
corporation, JANE ROE,)	
JOHN DOE, JAMES POE,)	
HAROLD GLUCKSBERG,	)	DECLARATION OF
M.D., ABIGAIL	)	JOHN DOE
HALPERIN, M.D.,)	
THOMAS A. PRESTON,)	
M.D., and PETER SHALIT,)	
M.D., Ph.D.,)	
)	
Plaintiffs,)	
)	
vs.)	
)	
THE STATE OF)	
WASHINGTON and)	
CHRISTINE GREGOIRE,)	
Attorney General of)	
Washington,)	
)	
Defendants.)	

_____)

JOHN DOE declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. John Doe is not my real name; I use this fictitious name in this lawsuit to protect my privacy.

3. I am 44 years old and am an artist.

4. I was diagnosed HIV positive in 1988 and diagnosed with AIDS in 1991. I have a T-cell count of 4, which means I have almost no immune system function.

5. My first major illness associated with AIDS was pneumocystic carinii pneumonia, which caused me to be hospitalized for approximately six weeks in the summer of 1992.

6. I experienced a second bout with AIDS-related pneumonia, nocardia, in January 1994. This illness required hospitalization for a period of almost two weeks.

7. I have had cytomegalovirus (CMV) retinitis [sic] since May 1993. This is destroying my retinas, and I am losing my vision. At the present time, I have lost 70% of my vision. I have been advised that I will lose 100% of my vision from this condition.

8. Loss of vision is fatal to my ability to paint.

9. I suffer chronic, severe sinus infections which I am unable to overcome because of my compromised immune state.

10. Also related to my AIDS, I suffer chronic skin infections and grand mal seizures.

11. In addition, my medical conditions leave me extremely fatigued. I live alone and I have noticed that my ability to care for myself is rapidly diminishing.

12. My long-term companion died of AIDS in June 1991. He was bedridden for six months prior to his death. He remained at home throughout his illness, and I

was his primary caregiver. He suffered from wasting syndrome, and at the time of his death he weighed only 60 pounds. I cared for his every physical need. I witnessed first-hand the pain, suffering, anguish, and loss of dignity of dying from AIDS. That experience, as well as my observation of my grandfather's death from diabetes, which included multiple amputations, loss of vision and loss of hearing, have led me to decide that when my inevitable dying process becomes unbearable, I wish to hasten that process.

13. My doctor has advised me that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures.

14. It is my desire that my physician prescribe suitable drugs for me to consume for the purpose of hastening my death.

15. I am mentally competent. I have no current or historical mental health problems that would impair my decision-making powers regarding end-of-life decisions.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at [not legible], this 1st day of February, 1994.

A/K/A JOHN DOE

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING,)	
a Washington nonprofit	)	NO. C94-119
corporation, JANE ROE,)	
JOHN DOE, JAMES POE,)	
HAROLD GLUCKSBERG,	)	DECLARATION OF
M.D., ABIGAIL	)	JAMES POE
HALPERIN, M.D.,)	
THOMAS A. PRESTON,)	
M.D., and PETER SHALIT,)	
M.D., Ph.D.,)	
)	
Plaintiffs,)	
)	
vs.)	
)	
THE STATE OF)	
WASHINGTON and)	
CHRISTINE GREGOIRE,)	
Attorney General of)	
Washington,)	
)	
Defendants.)	

_____)

JAMES POE declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. James Poe is not my real name; I use this fictitious name to protect my privacy.

3. I am 69 years old. I was a sales representative in the steel industry for all of my working life. My hobby of choice was fishing and, until my illness, I was an avid fisherman year-round.

4. I have suffered from emphysema for approximately nine years. My emphysema makes it extremely difficult for me to breathe. I have a constant sensation of suffocation.

5. In 1990, I underwent lung capacity testing and my doctor advised me that I had only 10 to 20 percent of lung function at that time.

6. I am connected to an oxygen tank at all times and I aspirate medications through a nebulizer for hours every day to facilitate my breathing.

7. Notwithstanding these measures to improve my breathing, I continue to be unable to get enough air and suffer panic associated with air hunger. I take medications, including morphine, regularly to calm the terror associated with the sensation of suffocation.

8. In addition to my emphysema, I suffer from heart failure related to my pulmonary disease. This condition obstructs the flow of blood to my extremities. I experience extreme leg pain and discomfort and am housebound.

9. The only comfortable times are when I am asleep. However, I have difficulty sleeping longer than two to three hours at a time.

10. Because of my condition, I am restricted to my home and have been for the past year.

11. I am not eligible for lung transplant because of my heart condition.

12. My doctors have advised me that I am in the terminal phase of this disease. It has been explained to me that there are no cures.

13. When my condition becomes unbearable, I wish to take drugs prescribed by my doctor for the purpose of hastening my death.

14. I am mentally competent. I have no current or historical mental health problems that would impair my decision-making powers regarding end of life decisions.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, Wa., this 1 day of Feb. 1., [sic] 1994.

A/K/A JAMES POE

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING,)	
a Washington nonprofit	)	NO. C94-119
corporation, JANE ROE,)	
JOHN DOE, JAMES POE,)	
HAROLD GLUCKSBERG,	)	DECLARATION
M.D., ABIGAIL	)	OF HAROLD
HALPERIN, M.D.,	)	GLUCKSBERG, M.D.
THOMAS A. PRESTON,)	
M.D., and PETER SHALIT,)	
M.D., Ph.D.,)	
)	
Plaintiffs,)	
)	
vs.)	
)	
THE STATE OF)	
WASHINGTON and)	
CHRISTINE GREGOIRE,)	
Attorney General of)	
Washington,)	
)	
Defendants.)	
_____)	

HAROLD GLUCKSBERG declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor specializing in oncology, which is the treatment of persons with cancer.

3. I received my medical education at the Buffalo Medical School in the State of New York, graduating in 1964.

4. I completed a Fellowship in hematology and oncology in the Department of Medicine at the University of Washington School of Medicine in Seattle, Washington in 1970.

5. I then completed a Senior Fellowship in oncology in the Department of Medicine at the University of Washington School of Medicine in Seattle, Washington in 1971.

6. I served as an Instructor and Senior Fellow in Medicine at the University of Washington School of Medicine in Seattle, Washington from 1971 through 1973.

7. During the years 1973 through 1975, I served as Assistant Professor of Medicine at the University of Washington School of Medicine.

8. From the years 1975 through 1976, I served as a Senior Lecturer in the Department of Medicine at the University of Dar Es Salaam in Tanzania, Africa.

9. I then served as Assistant Professor in Medicine at the University of Washington School of Medicine in Seattle, Washington and held that position through 1979.

10. During the years 1976 through 1979, I was an Assistant Member of the Fred Hutchinson Cancer Research Center in Seattle, Washington.

11. I served as an Attending Physician in the emergency departments of three New York hospitals during the years 1980 through 1982.

12. I acted as Regional Medical Officer for the Peace Corps in Senegal, Mali, Gambia, and Mauritania during the years 1982 through 1984.

13. Since 1985, I have practiced primary care adult medicine specializing in medical oncology at the Pacific Medical Center in Seattle, Washington. During this period, I have also served as Clinical Assistant Professor at the University of Washington School of Medicine.

14. I am certified by the National Board of Medical Examiners (1965), the American Board of Internal Medicine (1974), and the American Board of Medical Oncology (1979). I am licensed to practice medicine in Washington, New York and New Jersey.

15. I have published numerous articles and papers in medical journals. My full curriculum vitae is attached hereto as Exhibit 1.

16. Dying of cancer is usually very slow, occurring over months rather than days or weeks. General problems faced by most cancer patients include progressive loss of appetite, weight, and independence, and increasing pain and fatigue. In addition, there are a myriad of other problems related to the specific sites of the cancer. Those with cancer of the lung, for example, face terrible shortness of breath and cough. Those with a brain cancer often have excruciating headaches, seizures and progressive loss of brain function. Cancer usually progresses steadily and slowly. The cancer patient is fully aware of his or her present suffering and anticipates certain future suffering. The terminal cancer patient faces a future that can be terrifying. Near the end, the cancer patient is usually bedridden, rapidly losing mental and physical functions, often in excruciating, unrelenting pain. Pain management at this stage often requires the patient to choose between enduring unrelenting pain or surrendering an alert mental state because

the dose of drugs adequate to alleviate the pain will impair consciousness. Many patients will choose one or the other of these options; however, some patients do not want to end their days either wracked with pain or in a drug-induced stupor. For some patients pain cannot be managed even with aggressive use of drugs.

17. I occasionally encounter patients dying of cancer who have no chance of recovery, whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis who desire to hasten their deaths and avoid prolonged suffering. These patients cannot hasten their death without assistance or could do so but only at the risk of increased pain and anguish to themselves and their families.

18. It is my professional judgment that the decision of such a patient to shorten the period of suffering before death can be rational and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

19. Under the statute prohibiting assisting suicide, fulfillment of this professional responsibility might expose me to criminal prosecution. The statute deters me from treating these patients as I believe I should.

20. One patient of mine, whom I will call Jones, a fictitious name, was a 34-year old man dying of AIDS and lymphoma. I treated him during the last year of his life, the final four months of which were excruciatingly painful. Patient Jones had wasted away and suffered from CMV retinitis, which causes blindness. Patient Jones did not want to end his days in a lingering drug-induced stupor, the option available to him if he entered the hospital and was given continuously increasing amounts of morphine intravenously. Patient Jones requested that I prescribe drugs that he could take to hasten his inevitable death. As his

treating doctor, it was my professional opinion that patient Jones was competent to choose to shorten his period of suffering before death by taking drugs prescribed for that purpose. I felt that I should accommodate his request by prescribing such drugs. However, because of the statute I was unable to assist him in this way. Patient Jones ended his life by jumping from the West Seattle bridge. His physical condition was such that he could not have accomplished this without assistance, and it is my belief that he was aided by close family members. Such a violent end of life is inhumane for the patient and for his loved ones. In my opinion, patient Jones suffered more by dying in this manner than he would have if he had been able to self-administer drugs prescribed for the purpose of hastening his death.

21. Furthermore, patient Jones ran the risk of failing in his effort to hasten his death without medical assistance and could have suffered grievously if his effort had been unsuccessful.

22. Another patient of mine, whom I will call Smith, a 60-year-old man dying of metastatic lung cancer, was suffering terribly and requested that I prescribe drugs that he could take to hasten his inevitable death. Patient Smith was opposed to experiencing a lingering death with consciousness impaired by morphine. As his treating doctor, it was my professional opinion that patient Smith was competent to choose to shorten his period of suffering before death by taking drugs prescribed for that purpose. I felt that I should accommodate his request by prescribing such drugs. However, because of the statute, I was unable to assist him. Patient Smith's death dragged on for seven days, most of which was spent in a morphine-induced stupor, exactly as he had feared and desired to avoid.

23. The statute kept these patients from making fundamental decisions about medical care, their lives, their suffering and their dignity. The statute kept me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, Washington, this 2nd day of February, 1994.

/s/

HAROLD GLUCKSBERG, M.D.

Name: Harold Glucksberg, M.D.

Birthdate: October 18, 1939

Birthplace: Montreal, Canada

Domestic Status Married, 2 children

Citizenship: Naturalized, 1957, Brooklyn, New York

Education:

1956 - 1957: City College of New York

1957 - 1960: Queens College of New York

1960 - 1964: M.D., Buffalo Medical School, New York

Research and Professional Experience:

1964 - 1965: Internship in Medicine, King Country Hospital, New York City

1965 - 1966: Resident in Medicine, King Country Hospital New York City

1966 - 1969: Internal Medicine, U.S. Army

1969 - 1970: Fellow in Hematology and Oncology, Department of Medicine, University of Washington School of Medicine, Seattle, Washington

1970 - 1971: Senior Fellow in Onocology [sic], Department of Medicine, University of Washington School of Medicine, Seattle, Washington

EXHIBIT 1

- 1971 - 6/73: Instructor and Senior Fellow in Medicine, University of Washington School of Medicine, Seattle, Washington
- 7/73 - 6/75: Assistant Professor of Medicine, University of Washington School of Medicine
- 7/75 - 6/76: Senior Lecturer, Department of Medicine, University of Dar Es Salaam, Tanzania, Africa, (Sabbatical)
- 7/76 - 12/79: Assistant Professor of Medicine, University of Washington School of Medicine, Seattle, Washington
- 8/76 - 12/79: Assistant Member, Fred Hutchinson Cancer Research Center, Seattle, Washington
- 4/80 - 10/80: Assistant Professor of Nutrition, Tulane Medical School, Co-Director National Nutrition Center of Zaire
- 10/80 - 7/81: Attending Physician, Emergency Center Maimonides Medical Center, Brooklyn, New York
- 9/81 - 7/82: Attending Physician, Emergency Center, Coney Island Hospital, Brooklyn, New York
- 1/82 - 7/82: Attending Physician, Emergency Department, Brooklyn Jewish Hospital, Brooklyn, New York
- 8/82 - 11/84: Regional Medical Officer for Peace Corps (Senegal, Mali, Gambia and Mauritania)
- 1/85 - Present: Primary Care, Adult Medicine, Medical Oncology Pacific Medical Center, Seattle, Washington

Clinical Assistant Professor University
of Washington, School of Medicine

Military Status:

1966 - 1969: Internal Medicine, U.S. Army

Honors:

Gibson Honor Society; Mosby Book Award

Board Certification:

1965	Diploma of the National Board of Medical Examiners
1974	American Board of Internal Medicine
1979	American Board of Medical Oncology

Licensure:

Washington, New York, New Jersey

PUBLICATIONS

Harold Glucksberg, M.D.

1. Glucksberg, H. and Fefer, A.: Chemotherapy of Estavlished [sic] graft-sersus-host [sic] disease in mice. Transplantation 13: 300-356, 1972.
2. Thomas, E.D., Buckner, C.D., Clift, R.A., Fass, L., Fefer, A., Glucksberg, H., Johnson, F.L., Kane, P.J., Lerner, K.G., Neiman, P.E. and Storb, R.: Marrow grafting for aplastic anemia and for leukemia using HL-A matched donor-receipient [sic] sibling pairs. Exp. Hematol 22: 138-140, 1972.
3. Glucksberg, H. and Fefer, A.: The effect os [sic] splenectomy [sic] on graft-versushost [sic] disease (GVHD) in mice. J. Reticuloendothel. Soc 12: 537-544, 1972.
4. Buckner, C.D., Clift, R.A., Fefer, A., Funk, D.C., Glucksberg, H., Ramberg, R.E., Storf, R. and Thomas, E.D.: Aplastic anemia treated by marrow transplantation. Transplant. Proc. 5: 913-916, 1973.
5. Neiman, P., Wasserman, P.B., Wentworth, B.B., Kao, G.F., Lerner, K.G., Storb, R., Buckner, C.D., Clift, R.A., Fefer, A., Fass, L., Glucksberg, H. and Thomas, E.D.: Interstitial pneumonia and cyto magalovirus infection as complications of human marrow transplantation. Transplantation 15: 478-485, 1973.
6. Glucksberg, H. and Fefer, A.: Combination chemotherapy for clinically-established graft-versus-host disease (GVHD) in mice. Cancer Res. 33: 859-861, 1973.

7. Fefer, A., Buckner, C.D., Clift, R.A., Gass, L., Glucksberg, H., Mickelson, E.M., Neiman, P., Storb, R. and Thomas, E.D.: Marrow grafting and immunotherapy on identical twins with hematologic malignancies. Trans. Assoc. Am. Physicians 86: 178-184, 1973.
8. Storb, R. Buckner, C.D., Fefer, A., Clift, R.A., Neiman, P.E., Glucksberg, H., Lerner, K.G. and Thomas, E.D.: Marrow transplantation for aplastic anemia. Transplant. Proc. 6: 355-358, 1974.
9. Neiman, P., Thomas, E.D., Buckner, C.D., Storb, R. Fefer, A., Glucksberg, H., Clift, R.A. and Lerner, K.G.: Marrow transplantation for aplastic anemia and acute leukemia. Annu Rev. Med 25: 175-198, 1974.
10. Storb, R., Thomas, E.D., Buckner, C.D., Clift, R.A., Johnson, F.L., Fefer, A., Glucksberg, H., Giglett, E.R., Lerner, K.G., and Neiman, P.: Allogeneic marrow grafting for treatment of aplastic anemia. Blood 43: 157-180, 1974.
11. Fefer, A., Thomas, L.D., Buckner, C.D., Storb, R., Neiman, P., Glucksberg, H., Clift, R.A. and Lerner, K.G.: Harrow transplants in aplastic anemia and leukemia. Semin. Hematol. 11: 353-367, 1974.
12. Storb, R., Thomas, E.D., Buckner, C.D., Clift, R.A., Fefer, A., Glucksberg, H. and Neiman, P.E.: Transplantation of bone marrow in refractory marrow failure and neoplastic diseases. Am. J. Clin. Pathol. 62: 212-217, 1974.
13. Storb, R., Glucksman, E., Thomas, E.D., Buckner, C.D., Clift, R.A., Fefer, A., Glucksberg, H., Grahm, T.C., Johnson, F.L., Lerner, K.G., Neiman, P.E., and [sic] Ochs, H.: Treatment of established human graft-versus-host disease by antithymocyte globulin. Blood 44: 57-75, 1974.

14. Feffer, A., Einstein, A.B., Thomas, E.D., Buckner, C.D., Clift, R.A., Glucksberg, H., Neiman, P.E. and Storb, R.: Bone-marrow transplantation for hematologic neoplasia in 16 patients with identical twins. N. Eng. J. Med. 290: 1389-1393, 1974.
14. Buckner, C.D., Clift, R.A., Fefer, A., Funk, D.C., Glucksberg, H., Neiman, P.E., Paulsen, A., Storb, R. and Thomas, E.D.: High-dose cyclophosphamide (NSC-26271) for the treatment of metastatic testicular neoplasms. Cancer Chemother. Rep. 58: 709-714, 1974.
16. Glucksberg, H., Storb, R., Fefer, A., Buckner, C.D., Neiman, P.E., Clift, R.A., Lerner, K.G. and Thomas, E.D.: Clinical manifestations of graft-versus-host disease in human recipients of marrow from HL-A matched sibling donors. Transplantation 18: 295-304, 1974.
17. Buckner, C.D., Briggs, R., Clift, R.A., Fefer, A., Funk, D.D., Glucksberg, H., Neiman, P.E., Storb, R. and Thomas, E.D.: Intermittent high-dose cyclophosphamide (NSC-26271) treatment of stage III ovarian carcinoma. Cancer Chemother. Rep. 58: 697-703, 1974.
18. Storb, R., Thomas, E.D., Buckner, C.D., Clift, R.A., Johnson, F.L., Fefer, A., Glucksberg, H., Lerner, K.G., Neiman, P.E., Wiedem, P.L., and Wright, S.E.: Aplastic anemia (AA) treated by allogeneic marrow grafting. Transplant. Proc. 7: 813-816, 1965.
19. Glucksberg, H.: Cancer chemotherapy following tumor resection. Contemporary Surgery [sic] 6: 73-77, 1975.

20. Thomas, E.D., Storb, R., Clift, R.A., Fefer, A., Johnson, F.L., Neiman, P.E., Lerner, K.G., Glucksberg, H. and Buckner, C.D.: Bone Marrow transplantation. N. Eng. J. Med. 292: 832-843, 895902, 1975.
21. Glucksberg, H.: Cancer Chemotherapy. U.W. Medicine 2: 18-24, 1975.
22. Glucksberg, H., Buckner, C.D., Fefer, A., DeMarsh, Q., Coleman, D., Dobrow, R.B., Huff, J., Kjobeck, C., Hill, A.S., Dittman, W., Neiman, P.E., Cheever, M.A., Einstein, A.B., Jr., and Thomas, E.D.: Combination chemotherapy of adult acute non-lymphoblastic leukemia. Cancer Chemother Rep. 59: 1131-1137, 1975.
23. Fefer, A., Buckner, C.D., Thomas, E.D., Cheever, M.A., Clift, R.A., Glucksberg, H., Neiman, P.E., and Storb, R.: Cure of hemotologic [sic] neoplasia with transplantation of marrow from identical twins. N. Eng. J. Med. 297: 146-148, 1977.
24. Schauer, Peter K., Straus, David, J., Bagley, Charles M. Jr., Rudolph, Robert H., McCracken, Joseph D., Huff, John, Glucksberg, Harold, Bauermeister, Donald E., and Clarkson, Bayard D.: Angioummunoblastic Lymphadenopathy: Cancer. 48: 2493-2498, 1981.
25. Glucksberg, H.: Drug usage at Muhimbili Hospital: How appropriate? Dar Es Salaam Med J., in press.
26. Fefer, A., Cheever, M.A., Thomas, E.D., Boyd, C., Ramberg, R., Glucksberg, H., Buckner, C.D. and Storb, R.: Disappearance of ph¹ positive cells in four patients with chronic granulocytic leukemia after chemotherapy, irradiation and marrow transplantation from an identical twin. N. Eng. J. Med. 300: 333-337, 1979.

27. Glucksberg, H. and Singer, J.: CANCER CARE: A PERSONAL GUIDE. Johns Hopkins University Press, 1980.
28. Glucksberg, H., Rivkin, S.E. and Rasmussen, S.: Adjuvant Chemotherapy for stage II breast cancer: A comparison of CMFVP versus L-PAM (SWOG study) in ADJUVANT THERAPY OF CANCER II, pages 261-268, 1979.
29. Glucksberg, H., Cheever, M.A., Farewell, V.T., Fefer, A., Sale, G.E., and [sic] Thomas, E.D.: High dose combination [sic] chemotherapy for acute non-lymphoblastic leukemia in adults. Cancer, 48: 1073-1081, 1981.
30. Fefer, A., Cheever, M.A., Thomas, E.D., Appelbaum, F., Buckner, C.C., Clift, R.A., Glucksberg, H., Greenberg, P.D., Johnson, F.L., Kaplan, H.C., Sanders, J.E. and Storb, R.: Bone Marrow Transplantation for refractory acute leukemia in 34 patients with identical twins. Blood, 57: 421-430, 1981.
31. Rivkin, S.E., Glucksberg, H. and Rasmussen, S.: Adjuvant chemotherapy for operable breast cancer with positive axillary nodes : a comparison of CMFVP versus L-PAM (SWOG Study) in ADJUVANT THERAPY OF CANCER III, Jones, S. and Salamon., Grune and [sic] Stratton, Inc., pages 445-452, 1981.
32. Glucksberg, H., Rivkin, S.E., Rasmussen, S., Tranum, B., Nazli, G., Costanzi, J., Hoogstraten, B., Athens, J., Maloney, T., McCracken, J. and Vaughn, C.: Combination chemotherapy (CMFVP) versus L-phenylalanine mustard (L-PAM) for operable breast cancer with positive axillary nodes (SWOG Study), Cancer, 50: 423-434, 1982.

33. Glucksberg, H., Cheever, M.A., Farewell, V.T., Fefer, A. and Thomas, E.D.: Intensification therapy for acute non-lymphoblastic leukemia in adults. Cancer, 52: 198-205, 1983.
34. Glucksberg, H. and Singer, J.: The Multinational Drug Companies in Zaire: Their Adverse Effect on Cost and Availability of Essential Drugs, International Journal of Health Services, 12: 381-387, 1982.
35. Schauer, Peter K., Straus, David J., Bagley, Charles M. Jr., Rudolph, Robert H., McCracken, Joseph D., Huff, John, Glucksberg, Harold, Bauermeister, Donald E., and Clarkson, Bayard D.,: Angioimmunoblastic Lymphadenopathy: Cancer, 48: 2493-2498, 1981.
36. Glucksberg, H. and Singer, J.: CANCER CARE: A PERSONAL GUIDE. Charles Scribner's sons, 1982.
37. Rivikin, S.E., Glucksberg, H. and Foulkos, M.: Adjuvant chemotherapy [sic] for operable breast cancer with positive axillary nodes: a comparison of CMFVP versus L_PAM [sic] (SWOG Study) in ADJUVANT THERAPY OF CANCER III, Jones, S. and Salamon, S., Grune and Stratton, Inc., pages 209-215, 1984.
38. Knight III WA, Rivkin SE, Glucksberg H, Foulkes MA, Costanzi JJ, Stephens RL, Athens JW, O'Bryan RM. Adjuvant therapy of breast cancer: The Southwest Oncology Group Experience. Breast Cancer Res & Treat 3 (Suppl 1):27-33, 1983.
39. S.E. Rivkin, H. Glucksberg, and M. Foulkes. Recent results in Cancer Research: A Southwest Oncology Group Experience. Adjuvant Chemotherapy of Breast Cancer Springer-Verlag, pages 166-174; 1984.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING,)	
a Washington nonprofit	)	NO. C94-119
corporation, JANE ROE,)	
JOHN DOE, JAMES POE,)	
HAROLD GLUCKSBERG,	)	DECLARATION
M.D., ABIGAIL	)	OF ABIGAIL
HALPERIN, M.D.,	)	HALPERIN, M.D.
THOMAS A. PRESTON,)	
M.D., and PETER SHALIT,)	
M.D., Ph.D.,)	
)	
Plaintiffs,)	
)	
vs.)	
)	
THE STATE OF)	
WASHINGTON and)	
CHRISTINE GREGOIRE,)	
Attorney General of)	
Washington,)	
)	
Defendants.)	
_____)	

ABIGAIL HALPERIN declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.
2. I am a medical doctor specializing in family medicine and practice in Seattle, Washington.
3. I received my medical education at Albert Einstein College of Medicine in New York, completing my degree in 1983. Following graduation from medical school I completed a family practice residency at Swedish Hospital Medical Center in Seattle, Washington.
4. I then served as a staff physician at an international clinic in Kathmandu, Nepal from 1986 until 1987.
5. In 1987 I became a staff physician at Pacific Medical Clinic in Bellevue, Washington.
6. In 1988 I moved my practice to Uptown Family Practice in Seattle, Washington, which became Providence Uptown Medical Care Center in May 1992, where I continue to practice. I hold the position of Medical Director and Staff Physician.
7. I am licensed to practice medicine in the state of Washington; am certified by the American Board of Family Practice (1988); and am a member of the King County Medical Society and the American Academy of Family Physicians.
8. I hold an appointment as a Clinical Faculty member at the University of Washington School of Medicine, a position I have held since 1990.
9. In my medical practice, I occasionally treat patients with terminal illnesses, including cancer and AIDS.
10. Patients dying of both these diseases experience a steady degeneration of functional ability, increasing pain, fatigue and mental anguish.

11. At a certain point in the progression of many cancer patients' illness, there are no further curative treatment options. There are no curative treatment options for AIDS patients.

12. When curative treatments are not available, a variety of care options to maximize the patient's well being and comfort are available, however, at a certain point in the course of these diseases most patients are not able to be kept comfortable while maintaining a clear consciousness; the amount of pain medication necessary to resolve the pain causes loss of mental alertness and sometimes consciousness. Thus, these patients face the choice of enduring intractable pain or surrendering an alert mental state. Many patients will choose one or the other of these options; however, some patients do not want to end their days either wracked with pain or in a drug-induced stupor.

13. For some terminally ill patients, physical pain is a concern secondary to their mental anguish over their helplessness and loss of independence, dignity and autonomy.

14. I occasionally encounter terminally ill patients who have no chance of recovery whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis who desire to shorten the period of suffering before death. These patients either cannot hasten their death without assistance or could do so only at the risk of increased anguish and pain to themselves and their families.

15. It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational and on rare occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death

as an alternative to continuing palliative care if the patient so chooses.

16. Under the statute prohibiting assisted suicide, my fulfillment of this professional responsibility might expose me to criminal prosecution. The statute deters me from treating these patients as I believe I should and deprives my patients of their freedom to choose this type of medical care.

17. I recently had an experience where, in my professional judgment, a terminally ill patient of mine should have been able to choose to hasten her inevitable death with drugs prescribed for that purpose but was denied that option by the statute:

- a. Patient Smith (a fictitious name) was a woman in her eighties with metastatic breast cancer.
- b. Patient Smith had surgeries to remove both breasts and two courses of chemotherapy.
- c. Notwithstanding this aggressive surgical and medical treatment, the cancer metastasized and was causing progressive weakness, fatigue and loss of functional abilities.
- d. Patient Smith had always been active and independent; she expressed that she did not want to lose her independence and end her life in a hospital, subject to futile medical care; she desired the ability to control the manner and time of her death and requested that I prescribe drugs that she could take to hasten her inevitable death.
- e. As patient Smith's primary care doctor, it was my professional opinion that she was mentally competent to choose to shorten the

period of suffering before death. I felt that I should accommodate her request by prescribing such drugs. However, I was deterred from assisting this patient by the statute.

- f. Patient Smith acted on her own to hasten her death, by securing a plastic bag over her head and suffocating.
- g. In my opinion it is likely that patient Smith suffered more by dying in this manner than she would have if she had been able to self-administer drugs prescribed for the purpose of hastening her death.
- h. Furthermore, patient Smith ran the significant risk of failing in her effort to hasten her death without medical assistance and could have suffered disastrous consequences if her effort had been unsuccessful, such as oxygen deprivation-induced brain damage, which would have left her significantly mentally impaired and dependent on the type of intensive, invasive medical care and technology she most feared.
- i. The statute kept patient Smith from making fundamental decisions about her medical care, her life and autonomy, her suffering, her dignity, and her death. The statute kept me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 2 day of February,
1994.

/s/
ABIGAIL HALPERIN, M.D.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING,)	
a Washington nonprofit	)	NO. C94-119
corporation, JANE ROE,)	
JOHN DOE, JAMES POE,)	
HAROLD GLUCKSBERG,	)	DECLARATION
M.D., ABIGAIL	)	OF THOMAS A.
HALPERIN, M.D.,	)	PRESTON, M.D.
THOMAS A. PRESTON,)	
M.D., and PETER SHALIT,)	
M.D., Ph.D.,)	
)	
Plaintiffs,)	
)	
vs.)	
)	
THE STATE OF)	
WASHINGTON and)	
CHRISTINE GREGOIRE,)	
Attorney General of)	
Washington,)	
)	
Defendants.)	
)	

THOMAS A. PRESTON declares:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.
2. I am a medical doctor specializing in cardiology and am Chief of Cardiology at Pacific Medical Center in Seattle, Washington.
3. I received my medical education at the University of Pennsylvania, graduating in 1962.
4. Following graduation from medical school I completed an internship, residency and fellowship at the University of Michigan.
5. I served as a Special Research Fellow at the National Heart Hospital Institute of Cardiology in London, England, during 1967 and 1968.
6. Upon my return to the United States in 1968 I served as an Instructor of Internal Medicine, specializing in cardiology, at the University of Michigan through 1969. I then became Assistant Professor of Medicine at the University of Michigan and served in this capacity through 1972.
7. I served as Chief of the Cardiology Section at the Veterans Administration Hospital in Ann Arbor, Michigan, from 1968 through 1972.
8. From 1973 until 1980 I served as Associate Professor of Medicine at the University of Washington. Since 1980 I have held the position of Professor of Medicine at the University of Washington.
9. I served as Co-Director of the Division of Cardiology at Harborview Medical Center, Seattle, Washington from 1973 through 1975.
10. From 1975 through 1980 I served as Co-Director of cardiology at the United States Public Health Service Hospital in Seattle, Washington.

11. From 1980 through the present I have been Chief of the Cardiology Division at Pacific Medical Center in Seattle, Washington.

12. I have received numerous honors for medical teaching and writing and have published numerous articles and books in my field of professional expertise. My complete curriculum vitae is attached hereto as Attachment 1.

13. I am board certified in Internal Medicine (1971) and Cardiovascular Medicine (1974).

14. I am currently licensed to practice medicine in Washington. I am a Fellow of the American College of Cardiology and the American Heart Association Council on Clinical Cardiology.

15. In my medical practice I regularly treat patients dying from cardiopulmonary illnesses. Such patients commonly experience chest pain, breathlessness, dizziness, fainting and extreme weakness. The heart of this type of patient is so weak it can work no harder than it does at rest, rendering the patient unable to accomplish the smallest physical task or able to do so only with extraordinary effort, gasping for air. It is not uncommon, for example, for such patients to be unable to change position in bed. There is no chance of recovery for such patients unless a heart transplant, a treatment option available to only a small subset of patients, is performed. The terminal phase of heart failure can last for several months, and most patients know during that time that they are not eligible for a transplant.

16. I occasionally encounter terminally ill patients who have no chance of recovery, whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis, who desire to hasten their deaths and avoid prolonged suffering, and who cannot do so without

assistance or could do so but only at the risk of increased anguish and pain to themselves and their families.

17. It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

18. Under the statute prohibiting assisted suicide, fulfillment of this professional responsibility might expose me to criminal prosecution. The statute has caused me to do less than I otherwise would for these patients.

19. The statute has resulted in patients of mine dying tortured deaths.

20. The following example is illustrative of situations I have experienced in my career:

- a. Patient Jones (a fictitious name) had been in my care for approximately four years.
- b. Patient Jones suffered for three months in the final stages of heart disease, unable to get enough air, gasping even under an oxygen mask worn at all times.
- c. Patient Jones requested my assistance in hastening his inevitable death by prescribing drugs he could take for that purpose.
- d. Patient Jones was not eligible for a transplant, and had no chance of recovery. The patient understood this.
- e. Patient Jones was suffering terribly, and the suffering could not be relieved. It was my professional opinion as his treating doctor that patient Jones was mentally competent to make a choice with respect to shortening

his period of suffering before inevitable death. I felt I should accommodate his request.

- f. Nonetheless, I was deterred from assisting patient Jones by the statute.
- g. The statute kept the patient from making fundamental decisions about the patient's own medical care, his life, his suffering and his dignity. The statute kept me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, this 1 day of February, 1994.

/s/

THOMAS A. PRESTON, M.D.

CURRICULUM VITAE

THOMAS A. PRESTON, M.D.

SSN# 198-24-8933

Birth Date: June 17, 1933Birthplace: Philadelphia, PennsylvaniaCitizenship: U.S.A.

<u>Education:</u>	Swarthmore College	1951-55
	Swarthmore, Pennsylvania,	
	University of Pennsylvania	1958-62
	Philadelphia, Pennsylvania	
	B.S. Electrical Engineering	1955
	M.D. University of Pennsylvania	1962

Marital: Married (Molly), two daughtersMilitary Service:

U.S. Army 1956-58

Postgraduate Training:

Internship:	University of Michigan	1962-63
	Medical Center	
Residency:	University of Michigan	1963-66
	Internal Medicine	
Fellowship:	University of Michigan	1966-67
Specialty:	Special Research Fellow	1967-68
	National Heart Hospital	
	Institute of Cardiology	
	London, England	

ATTACHMENT 1

Faculty Positions:

Instructor in Internal Medicine (Cardiology), University of Michigan	1968-69
Assistant Professor of Medicine [sic] University of Michigan	1969-1972
Associate Professor of Medicine University of Washington	1973-1980
Professor of Medicine University of Washington	1980-

Hospital Positions:

Chief, Cardiology Section Veterans Administration Hospital Ann Arbor, Michigan	1968-1972
Co-Director, Division of Cardiology Harborview Medical Center Seattle, Washington	1973-1975
Co-Director, Cardiology U.S.P.H.S. Hospital Seattle, Washington	1975-80
Chief, Cardiology Division Pacific Medical Center Seattle, Washington	1980-

Honors:

American College of Cardiology Young Investigator Award Second Place University of Michigan Medical Center	1966
Resident Achievement Award University of Michigan Medical School	1966
Senior Class Award for Best Teacher University of Michigan	1970, 1972
	1971

Distinguished Service Award
 University of Michigan Medical Center 1972
 Resident Award to
 Outstanding Faculty Teacher
 University of Washington Medical School 1974,75,
 Senior Class Award to 1977,78
 Outstanding Clinical Teacher
 The National Association of Science 1983
 Writers “Science-in-Society”
 Journalism Award

Administrative Service:

University of Michigan Medical School 1970-72
 Senior Counselor
 University of Michigan Medical School
 Mentor, Class of 1974

Board Certification:

Diplomate, American Board of 1971
 Internal Medicine
 Subspecialty Board Certification: 1974
 Cardiovascular

Licensure:

Pennsylvania (inactive) 1963
 Michigan (inactive) 1964
 Washington 1973

Organizations:

Fellow
 American College of Cardiology
 Fellow, American Heart Association
 Council on Clinical Cardiology

BIBLIOGRAPHY

Thomas A. Preston, M.D.

Completed Publications in Scientific Journals:

1. Preston, T.A., Judge, R.D., Bowers, D.L. and Morris, J.D.: Measurement of Pacemaker Performance. *Am. Heart J.* 71:92-99, January 1966.
2. Preston, T.A., Judge, R.D., Lucchesi, B.R. and Bowers, D.L.: Myocardial Threshold in Patients with Artificial Pacemakers. *Am. J. Cardiol.* 18:83-89, July 1966.
3. Preston, T.A. and Judge, R.D.: High Myocardial Threshold to an Artificial Pacemaker — Report of a Fatal Case. *NEJM* 276:798-799 (April 6), 1967.
4. Preston, T.A., Fletcher, R.D., Lucchesi, B.R. and Judge, R.D.: Changes in Myocardial Threshold, Physiologic and Pharmacologic Factors in Patients with Implanted Pacemakers. *Am. Heart J.* 74:235-242, August 1967.
5. Preston, T.A. and Judge, R.D.: Alteration of Pacemaker Threshold by Drug and Physiologic Factors. *Annals to the New York Academy of Sciences*, Vol. 167, Art. 2, 686-692, October 30, 1969.
6. Sowton, E., Balcon, R., Preston, T., Leaver, D. and Yacoub, M.: Long-term Control of Intractable Supraventricular Tachycardia by Ventricular Pacing. *British Heart Journal*, 31:700-706, November 1969.
7. Kirsh, M., Orvald, T., Preston, T. and Kahn, D.: Pulmonary Hypertension — A Complication of Aortic Valve Disease. *Michigan Medicine*, 69:33-35, Jan. 1970.

8. Preston, T.A.: Medical Treatment of Complete Heart Block and Pacemaker Complications. Univ. of Mich. Med. Center Journal, 36:18-20, Jan.-March, 1970.
9. Preston, T.A.: A Simple Clinical Method of Estimating Arterial Pulse Rise Time. Am. Heart J. 80:475-478, 1970.
10. Sowton, E., Gray, K. and Preston, T.A.: Electrical Interference in Non-Competitive Pacemakers. British Heart Journal, 32:626-632, 1970.
11. Preston, T.A., and Kirsh, N.M.: Permanent Pacing of the Left Atrium for Treatment of W-P-W Tachycardia. Circulation, 42:1073-1077, 1970.
12. Preston, T.A.: Chronic Threshold Measurement. Annales de Cardiologie et D'Angeologie, 20: 501-502, 1971 (July-August).
13. Davidson, D.M., Braak, C.A., Preston, T.A., and Judge, R.D.: Permanent Ventricular Pacing. Effect on long-term survival, congestive heart failure, and subsequent myocardial infarction and stroke. Ann Int Med 77:345-351, 1972.
14. Wheatley, C.E., Preston, T.A., Weaver, D.K., and DeYoung, W.A.: Complete Heart Block Due to Metastatic Rhabdomyosarcoma. Univ. of Mich. Med. Center Journal, 28:67-70, 1972.
15. Preston, T.A.: Electrocardiographic Diagnosis of Pacemaker Catheter Displacement. Am Heart J., 85:445-451, 1973.
16. Yates, J. and Preston, T.A.: Failure of Demand Function in Temporary Epicardial Bipolar Pacemaker Systems. Annals of Thoracic Surgery, 15:135-139, 1973.

17. Preston, T.A., Yates, J.D. and Brymer, J.F.: Three Therapeutic Approaches in Tachycardia. *Geriatrics* 28:110-117, 1973.
18. Preston, T.A. and Rush, J.B.: Transient Left Bundle Branch Block and Angina Pectoris, *The University of Michigan Medical Center Journal* 39:27-29, 1973.
19. Preston, T.A. and Yates, J.D.: Management of Stimulation and Sensing Problems in Temporary Cardiac Pacing. *Heart and Lung* 2:533-538, 1973.
20. Preston, T.A.: Anodal Stimulation as a Cause of Pacemaker Induced Ventricular Fibrillation. *Am Heart J.* 86:366-372, 1973.
21. Preston, T.A. and Bowers, D.L.: Report of a Continuous Threshold Tracking System. *Cardiac Pacing, Proceedings of the Fourth International Symposium.* Thalen, H.J. (Editor). Van Gorcum, Assen, The Netherlands, 1973. p 295-299.
22. Preston, T.A.: A New Temporary Pacing Catheter with Improved Sensing and Safety Characteristics, *Am Heart J.* 88:289-293, 1974.
23. Preston, T.A., and Bowers, D.L.: The Automatic Threshold Tracking Pacemaker, *Medical Instrumentation* 8:322-325, 1974.
24. Preston, T.A.: How Would You Like to be Stimulated? Monopolar or bipolar? *Stimocoeur* 2: (No. 4) 83-87, 1975. (French)
25. Preston, T.A. and Bowers, D.L.: Clinical Applications of the Threshold Tracking Pacemaker. *Amer. J Cardiol.* 36:322-326, 1975.
26. Preston, T.A.: Temporary Unipolar Pacing Using a Dual Cathode. *J Electrocardiology* 9(2):193-197, 1976.

27. Preston, T.A.: The Use of Pacemaking for the Treatment of Acute Arrhythmias. *Heart and Lung*, 6:249, 1977.
28. Preston, T.A., Barold S.S.: Problems in the Measurement of Threshold for Cardiac Pacing. *Amer J Cardiol*. 40:658-660, 1977.
29. Richtsmeier, T.E., Preston, T.A.: Drug Management of Stable Angina Pectoris, *Postgraduate Med* 62:91-100, 1977.
30. Preston, T.A.: The Hazard of Poorly Controlled Studies in the Evaluation of Coronary Artery Surgery. *Chest* 73:441-442, 1978.
31. Preston, T.A., Preston, A.W.: The Automatic Rate Adjustment Pacemaker. The Possibilities of Rate Hysteresis. *PACE* 1:178-185, 1978.
32. Preston, T.A.: Journalistic Differentiation of Hypothesis and Conclusion in Reports of Therapy. *Archives of Intern Med*. Vol 138:687-688, May 1978.
33. Preston, T.A.: Future Trends in Pacing. *Heart and Lung*, 7:781-782, 1978.
34. Preston, T.A.: Operating in the Dark. *The Sciences* 18: No. 8 (Oct) 20-23, 1978.
35. Preston, T.A., Haynes, R.E., Gavin, W.A. and Bessel, E.A.: Permanent Rapid Atrial Pacing to Control Supraventricular Tachycardia. *PACE* 2:331-334, 1979.
36. Preston, T.A.: Measuring Ventricular Function After Coronary Artery Surgery. *Amer Heart J* 99:270-272, 1980.
37. Preston, T.A.: Pacemaker Utilization: The Need for Information. *PACE* 4:235-238, 1981.

38. Greene, H.L., Gross, B.W., Preston, T.A., Werner, J.A., Kime, G.M., Hessel, E.A., Weaver, W.D., Duncan, J.L. Termination of ventricular tachycardia by programmed extrastimuli from an externally-activated permanent pacemaker. *PACE* 5:434-439, May-June 1982.
39. Phibbs, B., Friedman, H.S., Graboys, T.B., Lown, B., Marriott, H.J.L., Nelson, W.P., Preston, T.: Indications for Pacing in the Treatment of Bradyarrhythmias. *JAMA* Vol. 252:1307-1328, 1984.
40. Preston AW, and Preston TA. The patent system and cardiac pacing: Is the system serving its users? *PACE* Vol. 8:476-483, July-August 1985.
41. Preston, TA. Bypass surgery: It has merit, but it's being abused. *Modern Medicine* Vol. 53(11):11-16, 1985.
42. Preston, TA. Should economics determine the cost of a life? *Medical Ethics* Vol. 2:12, 1987.
43. Preston, TA. Assessment of coronary bypass surgery and percutaneous transluminal coronary angioplasty. *Intl. J. of Technology Assessment in Health Care*, 1989, 5, 431-442.

ABSTRACTS:

1. Mowry, R.M., Judge, R.D., Preston, T.A., and Morris, J.D.: Identification and Management of Exit Block in Patients with Implanted Pacemakers. *Circulation* 32:11-157, October 1965.
2. Preston, T.A., Judge, R.D., Bowers, D.L. and Morris, J.D.: Myocardial Threshold and Impedance in Complete Heart Block: Methods for Assessing Pacemaker Function and Malfunction. *Circulation*, 32:11-173, Oct. 1965.
3. Preston, T.A.: Atrial Phasic Inhibition of Implanted Cardiac Pacemakers. *Circulation*, 38:VI-158, Oct. 1968.
4. Sowton, E., Preston, T.A., Barcelo, J., and Balcon, R.: Two Years Experience with Implanted Demand Pacemakers, *British Heart Journal*, 31:389, 1969.
5. Good, A., and Preston, T.: Atrio-ventricular block in Ankylosing Spondylitis. *Circulation*, 42:III- 159, Oct. 1970.
6. Preston, T.A. and Rush, J.B.: A New Type of Permanent Pacemaker for Treating W-P-W Tachycardia. *Circulation*, 42:III- 189, Oct. 1970.
7. Preston, T.A., Davidson, D.M., Braak, C.A., and Judge, R.D.: Permanent Ventricular Pacing - A Review of Nine Years Experience. *Ann. Int. Med* 74:821, 1971.
8. Preston, T.A. and Reynolds, E.W.: Make-Break Cardiac Stimulation. *Journal of the Assoc. for the Advancement of Medical Instrumentation*, 6:185-186, 1972.
9. Preston, T.A. and Bowers, D.L.: Continuous Threshold Tracking System. *Circulation*, 48:IV-123, 1973.

ARTICLES IN BOOKS:

Preston TA: Indications for atrial pacing. In, Modern Cardiac Pacing, S. Furman and DJW Escher, editors, Charles Press, Bowie, MD. 151-155, 1975.

Preston TA: Non-nuclear energy sources, Ibid, 226-230.

Preston TA: Pacer-induced ventricular tachycardia, Ibid, 250-255.

Pribble AR, Preston TA: Electrocardiographic changes. In, Mosby's Comprehensive Review of Critical Care, DA Zachosche, editor. CV Mosby Co, St. Louis 135-167, 1976.

Preston TA: Influence of electrode positions on pacing threshold and sensed signals. In, Cardiac Pacing, Y Watanabe, editor, Excerpta Medica, Amsterdam 429-432, 1977.

Page RD, Preston TA: Atrial fibrillation. In, Current Therapy, 1980, pg 169-172.

Preston TA, Petersdorf RG: Are there too many cardiologists and are they doing the wrong thing? In, Current Controversies in Cardiovascular Disease, editor Elliot Rapaport, M.D., W.B. Saunders Company, Philadelphia, 1980.

Preston, TA: Ventricular arrhythmias, In, Arrhythmias of the Heart, ed: J. Nieveen, Excerpta Medica, Amsterdam, 1981, p 94-104.

Preston, TA: The Artificial Heart. In, Worse Than The Disease, Dutton, DB, Ed. Cambridge University Press, 1988, p 91-126.

BOOKS:

Preston TA: Coronary Artery Surgery: A Critical Review. Raven Press, New York, 1977.

Preston TA: The Clay Pedestal. Madrona Publishers, Seattle, 1981. Scribner's, paperback, 1986.

MAGAZINE/NEWSPAPER ARTICLES:

1. The Case Against the Artificial Heart. The Seattle Weekly, March 30, 1983, and Utah Holiday, June, 1983. (Received National Association of Science Writer's Science-in-Society Journalism award for 1983.)
2. The Artificial Heart and the Public Purse. Medical World News, September 10, 1984.
3. Baby Fae: The Ethics of Medical Adventurism. The Washington Post, November 14, 1984.
4. Baby Fae'—What Does She Mean to Us? Medical World News, November 26, 1984.
5. Marketing an Operation. The Atlantic Monthly, December, 1984.
6. Who Benefits From the Artificial Heart? The Hastings Center Report, February 1985.
7. The Great Medical Robbery [sic]. The Seattle Weekly, November 21, 1990.
8. Business Can't Cope With Organized Medicine. Seattle Times, April 26, 1992, p. A17
9. Healthcare Reform—Ban Reimbursement. Medical World News, October 1992, p. 47.

Monthly column on medical ethics, CARDIO, Jan-Dec, 1984.

Monthly column on medical ethics, Medical World News, Jan, 1985 to ~~present~~ 1987.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING,)	
a Washington nonprofit	)	NO. C94-119
corporation, JANE ROE,)	
JOHN DOE, JAMES POE,)	
HAROLD GLUCKSBERG,	)	DECLARATION
M.D., ABIGAIL	)	OF PETER
HALPERIN, M.D.,	)	SHALIT, M.D., Ph.D.
THOMAS A. PRESTON,)	
M.D., and PETER SHALIT,)	
M.D., Ph.D.,)	
)	
Plaintiffs,)	
)	
vs.)	
)	
THE STATE OF)	
WASHINGTON and)	
CHRISTINE GREGOIRE,)	
Attorney General of)	
Washington,)	
)	
Defendants.)	
_____)	

PETER SHALIT declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor and received my medical degree from the University of Washington in 1985.

3. Prior to obtaining my medical degree, I received a Ph.D. in Genetics from the University of Washington in 1981. While pursuing my Ph.D. I served as a National Science Foundation Fellow and a National Institute of Health Trainee.

4. After obtaining my medical degree I completed an internship in the Department of Psychiatry and a residency in the Department of Medicine at the University of Washington in Seattle, Washington.

5. From 1989 to 1990 I served as Chief Medical Resident at Providence Medical Center in Seattle, Washington.

6. Since 1990 I have been in private practice specializing in general internal medicine in Seattle, Washington. I hold staff privileges at Swedish Hospital Medical Center and Providence Medical Center.

7. I am certified by the American Board of Internal Medicine (1989) and am licensed to practice medicine in the State of Washington.

8. I have served as the Medical Director of the Seattle Gay Clinic since 1989.

9. I have served as a Clinical Instructor in Medicine in the Division of Allergy and Infectious Diseases, Department of Medicine, University of Washington since 1990.

10. I have served as Attending Physician at the Madison Clinic, an HIV clinic affiliated with Harborview Medical Center in Seattle, Washington, since 1990.

11. A substantial portion of my private practice involves treatment and care of persons with HIV infection and AIDS.

12. Infection with HIV, the Human Immunodeficiency Virus, produces progressive destruction of the immune system, leading to a condition known as the Acquired Immune Deficiency Syndrome, or AIDS, which is inevitably fatal. Persons with AIDS are vulnerable to a variety of unusual infections, cancers, and other syndromes such as dementia (progressive loss of cognitive function), wasting (chronic diarrhea/weight loss), and peripheral neuropathy (nerve damage causing burning or shooting pain in the limbs). Death is often preceded by a prolonged period of illness and debility, especially as medical science becomes better at preventing and treating AIDS-related infections.

13. Patients with AIDS may die in many different ways. Many suffer from Kaposi's Sarcoma, a common AIDS-related cancer. These patients frequently die from invasion of this cancer into the lungs, causing progressive difficulty breathing and ultimately death by suffocation. Many die of pneumonia, which also causes the patient to essentially suffocate. Many with wasting or dementia basically die of starvation and dehydration, a process that can take weeks and can be excruciating; some of the patients lose so much weight that they appear skeletal and their bones may break through their skin. Still others die as the result of some massive infection that resists treatment.

14. Many AIDS patients who will die of the above-described causes also suffer from conditions which themselves cause extreme pain and suffering. Examples include CMV retinitis, which leads to loss of vision and eventually blindness; neuropathy, which sometimes causes

pain so agonizing that it can be relieved only by a dosage of narcotics which impairs consciousness; Kaposi's Sarcoma of the skin, which can produce severe disfigurement and pain from swollen tissues and open, weeping skin lesions.

15. Medicines can palliate the dying process in many cases. The majority of the time, I am able to ameliorate the symptoms of a dying patient so that the patient can be relatively free from pain and discomfort while dying. However, in some cases, the pain, discomfort, and loss of dignity can be relieved only with drugs which render the patient unconscious; in some cases even such aggressive use of drugs does not bring relief. In my five years of practice I have had numerous AIDS patients receiving hospice care who repeatedly express frustration at how long the process is taking, and how painful, uncomfortable, and humiliating it is. Some of these patients have made repeated requests that their dying process be hastened.

16. I occasionally encounter terminally ill patients who have no chance of recovery whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis who desire to hasten their death and avoid prolonged suffering. These patients cannot hasten their death without assistance, or could do so but only at the risk of increased anguish and pain to themselves and their families.

17. It is my professional judgment that the decision of such a patient to shorten the period of suffering before death can be rational and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

18. Under the statute prohibiting assisted suicide, fulfillment of this professional responsibility might

expose me to criminal prosecution. The statute deters me from treating these patients as I believe I should.

19. The statute has resulted in patients of mine dying tortured deaths.

20. One patient of mine, whom I will call Smith, a fictitious name, lingered in the hospital for weeks, his lower body so swollen from oozing Kaposi's lesions that he could not walk, his genitals so swollen that he required a catheter to drain his bladder, his fingers gangrenous from clotted arteries. Patient Smith's friends stopped visiting him because it gave them nightmares. Patient Smith's agonies could not be relieved by medication or by the excellent nursing care he received. Patient Smith begged for assistance in hastening his death. As his treating doctor, it was my professional opinion that patient Smith was mentally competent to make a choice with respect to shortening his period of suffering before inevitable death. I felt that I should accommodate his request. However, because of the statute, I was unable to assist him and he died after having been tortured for weeks by the end-phase of his disease.

21. Such a prolonged dying period is inhumane to the patient, who must suffer against his wishes, and to the loved ones, who frequently express the belief that "we are kinder to our pets than we are to the terminally ill." After death, the survivors have guilt about the suffering their dying loved-one endured, and the doctor feels remorse that the patient's suffering could not have been better relieved.

22. More than once I have had an AIDS patient commit suicide relatively early in the course of the disease, apparently fearing that a death like patient Smith's will be their fate. Feeling unable to discuss their fears with me or with their family, and anticipating an illness which will end in unrelieved suffering without the possibility of assisted

voluntary exit, these individuals prematurely end their lives on their own, usually through a violent means. They leave behind grief-stricken family members who have not had the opportunity to say good-bye, and a doctor who wishes he could have prevented their premature death by committing to help them through the subsequent stages of their illness, including the promise of provision of the means of release from unbearable suffering should they so choose at that time.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 1st day of February, 1994.

/s/
PETER SHALIT, M.D., Ph.D.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING,)	
a Washington nonprofit	)	NO. C94-119
corporation, JANE ROE,)	
JOHN DOE, JAMES POE,)	
HAROLD GLUCKSBERG,	)	DECLARATION
M.D., ABIGAIL	)	OF KATHRYN
HALPERIN, M.D.,	)	L. TUCKER
THOMAS A. PRESTON,)	
M.D., and PETER SHALIT,)	
M.D., Ph.D.,)	
)	
Plaintiffs,)	
)	
vs.)	
)	
THE STATE OF)	
WASHINGTON and)	
CHRISTINE GREGOIRE,)	
Attorney General of)	
Washington,)	
)	
Defendants.)	
_____)	

KATHRYN L. TUCKER declares:

1. I am counsel to plaintiffs in this matter, am competent to testify and do so of my own personal knowledge.

2. The three terminally ill plaintiffs in this lawsuit appear with fictitious names. These individuals desire that their true identities not be revealed.

3. In support of Plaintiffs' Motion for Summary Judgment, declarations of each of the terminally ill plaintiffs are submitted.

4. The signature page of the declaration of each terminally ill plaintiff has been redacted to conceal the true name of the plaintiff. The originals of each of these signature pages are maintained at my office. This is necessary to maintain the privacy of the terminally ill plaintiffs.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 2 day of February, 1994.

_____/s/_____
KATHRYN L. TUCKER